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MID-TERM EVALUATION

CHILD SURVIVAL PROJECT GANZOURGOU, BURKINA FASO AFRICARE

MARCH --- APRIL 1995

'Improving the quality of life in rural Africa through the development of water resources. Increased food production and the delivery of health services.'

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BURKINA FASO---CHILD SURVIVAL MID-TERM EVALUATION

From Laura Hoemeke, HQ CSP Manager for West Africa

The following are strengths of the project that were noted during the Mid-Term Evaluation. Although some of these strengths are mentioned in this report, others may not be explicitly stated or may need clarification.

1) Project Coordinator

The project coordinator has remained committed to the project despite many constraints, both internal and external. The evaluation team felt that she is capable of managing the project and, by applying some of the lessons learned during the evaluation, providing solid direction to the project during its last year.

(Note: Africare/W has noticed improvements in quality of the PC's work in the few months sonce the MTE.)

2) Quality of Work/Motivation of Health Promoters

Although the project has had internal staffing problems on the level of office staff, the field staff--especially the health promoters--has performed well since the beginning of the project. During observations of health talks and growth monitoring/promotion sessions, the evaluation team noticed the health promoters appeared to be qualified to perform their duties. The major lessons learned regarding the health promoters was the training they had received and the monotony of using the same health education techniques. (These lessons learned were defined and elaborated upon by the promoters themselves.)

3) Collaboration with other Agencies/Services

The project had successfully collaborated with APAIB/WINS and UNICEF, supporting the activities of both of these agencies. In addition, although problems were noted in the communication between the project and the provincial health department, it should be noted that linkages and collaboration did exist between the project and the PHD.

4) Changes in KAP (especially K) in Mothers

The mid-term evaluation included a Rapid KPC Survey, which was designed not necessarily to measure impact, but rather to give useful information to project staff.

The survey revealed that mothers' knowledge regarding various interventions had increased. (The only criticism here was that these improvements in knowledge have not yet been linked definitely to changes in behavior.) The knowledge of mothers directly reflects what they have learned from the health promoters. (For example, messages on control of diarrhea1 disease focused on ORS packets. The mothers mentioned ORS most often in described appropriate management of diarrhea.) This indicates that the health promoters were effective in their education activities.

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MID-TERM EVALUATION
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EXECUTIVE SUMMARY

A mid-term evaluation of Phase II of Africares' Child Survival Project in Ganzourgou, Burkina Faso, was conducted from March 13 to April 3, 1995. The evaluation was coordinated by an external consultant, Judi Aubel , PhD, MPH, assisted by Laura Hoemeke, Child Survival Program Manager/Africare. A participatory methodology was used and all the Atiicare project staff as well as partners in the Department of Zorgho (a total of 21 team members) were involved in all the phases of the process. The goal of the evaluation was to analyze the strategies and activities implemented to date in order to draw lessons to apply to reinforce the project in the future.

Programmatic conclusions

The results of the evaluation were formulated as "lessons learned" relating both to the fundamental strategy defined in the project paper and to the effectiveness of the implementation of this strategy. The results of the evaluation question the fundamental strategy of the project (project design) concerning changes in the behavior of mothers. Like most 'child survival' (CS) programs, the Ganzourgou Child Survival Project (GCSP) strategy is based on the assumption that changes in the knowledge and attitudes of mothers toward child survival will result in an improvement in their practices. The conclusion of this evaluation is that, in general, the attitudes and behaviors of women are more influenced by community norms than by their own knowledge. Experience shows that all CS projects need to focus on the changes of knowledge and attitudes of influential individuals in the community (old women, husbands, village chiefs and other family members) as well as those of the mothers.

Health education activities

The projects' activities are focused on health education. The approach that had been used in the various activities (group discussions, home visits, community meetings and health talks) focused on communicating messages on the various topics related to CS. The findings of the evaluation revealed that in order to increase the impact of these activities, this approach must be revised to put more emphasis on active, participatory learning and adult education principles. In this approach, educational activities must be based oian in-depth analysis of the CS themes by the members of the community rather than on a simple transfer of messages and advice.

Sustainability of community-based CS promotional activities

Several aspects of the current community approach call into question the probability that improved health practices and the promotion of CS will be sustained after the project. Many lessons learned relate to ways in which the project can encourage and foster sustainability: (1) reduce reliance on project staff by increasing the role of community actors; (2) intensify the acquisition of knowledge and skills by community actors to promote CS; (3) establish a system of supervision and continued encouragement of these actors by the community itself; and (4) promote the use of traditional channels of communication as a means of sharing health information.

Staff and project management

The Zorgho Project encountered a myriad of problems in the past due to a lack of adequate and positive support from the Africare office in Ouagadougou. With the change of staff at this office, there now exists cooperation between the two offices. In Zorgho, most members of the project staff are competent and motivated, and under the supervision of the project coordinator. the team spirit is also improving.

Methodological conclusions on the participatory approach of the evaluation

The evaluation methodology engaged the active participation of all the project staff and several collaborators/partners. Concerning the relevance of the participatory methodology; feedback from the evaluation team members was favorable. Although the participatory methodology adopted was appreciated by Africare staff and management, the three weeks spent for the evaluation were very short. In the future, four weeks need to be allocated when this participatory approach is adopted.

INTRODUCTION

This report describes the findings of the mid-term evaluation of Phase II of Africares' Ganzourgou Child Survival Project (GCSP), conducted from March 13 to April 3, 1995, in Burkina Faso. The participatory methodology used is also described in detail. The format of this report should make it useful as a guide for Africare staff and partners involved in the GCSP. This report is also a means of sharing the lessons learned. In addition to lessons learned, this report will be useful to those who want to use participatory methodology in their evaluation activities.

A. CONTEXT/BACKGROUND OF THE EVALUATION

The Phase II of the GCSP has the goal of reducing child and maternal mortality and morbidity. The target populations of the project are children under five years of age, pregnant women, and women of reproductive age.

The project, which is funded by USAID (the United States Agency for International Development), implements the national health policies defined by the MOH (Ministry of Health) of Burkina Faso.

Phase I of the project, September 1990 through August 1993, was implemented in 14 villages in the Department of Meguet, in the Province of Ganzourgou. Activities during Phase I addressed five technical components identified as key aspects of child survival: (1) promotion of immunization; (2) prevention and treatment of diarrhea1 diseases; (3) growth monitoring and child nutrition; (4) maternal health; (5) family planning and birth spacing. Activities were implemented in the project villages by five project health promoters assisted by volunteer neighborhood counselors. At the end of Phase I, a final evaluation was conducted and recommendations were made relating to the sustainability of the activities and the implementation of Phase II.

Phase II of the project started in September 1993. The goal of this phase is to continue the activities of Phase I in the 14 villages, and to expand activities to nine additional villages. During Phase II, activities focus on the technical components covered during Phase I, with the additional components of AIDS education and malaria prevention and control. During this phase, the project has increased the number of its staff to six female and three male health promoters.

This mid-term evaluation covers the first 17 months of implementation of this three-year project. The evaluation was scheduled for March 1995 to allow enough time to apply the results and lessons learned during the second half of the project (18 months).

B. METHODOLOGICAL OPTION: PARTICIPATORY EVALUATION

There are many different approaches used in evaluating programs. The choice of a methodology depends on the goal of the evaluation. In the context of child survival projects, the mid-term evaluation is a process evaluation, which aims at analyzing the strategies and activities implemented in order to develop recommendations for improving the implementation of the project. Based on this goal, a participatory evaluation focusing on qualitative analysis of the strategies and activities was determined to be the most appropriate in this situation.

A key aspect of the participatory methodology adopted in this evaluation focused on the identification of the strengths and weaknesses in the implementation of the child survival (CS) strategies and activities. This resulted in the formulation of lessons learned to build upon in future project implementation.

In the traditional approach to evaluation, one or several evaluators (usually external consultants), are selected and entrusted with conducting the evaluation which includes developing questionnaires, designing the methodology, collecting and analyzing data, and formulating conclusions and recommendations for the project. In this approach, actors and partners of the project are involved only by responding to questions asked by the evaluators.

In the participatory approach to evaluation, planning and implementation of the evaluation are to be performed not only by external evaluators, but actors and partners of the project as well. The evaluation team members work together to develop the evaluation questionnaire and methodology, and to collect and analyze the data. They also formulate the conclusions and recommendations for the project. In this approach, the role of the external evaluator is to organize all the phases of the evaluation, ensure the participation of the team in each phase and provide input based on his or her own observations and experience. The role of the actors and partners of the project consists of sharing their experiences in working with the project, providing assistance in data collection and analysis, and formulating conclusions geared towards the reinforcement of project strategies.

In the participatory approach, the participation of the actors and partners of the project should ensure that the evaluation responds to their questions and concerns. In addition, their participation should ensure the appropriateness of the evaluation recommendations and their applicability. In so doing, ensuring that at the end of the evaluation the report will not be the only output. Generally, participants will start developing the ability to evaluate their own activities and will have a better understanding of the strengths and weaknesses of their project.

C. GOAL AND OBJECTIVES OF THE EVALUATION

Based on the general expectations of this evaluation, the goal of the evaluation was defined by Africare staff members and the evaluation consultant. The goal defines the qualitative nature of the evaluation and emphasizes the need to formulate lessons to improve the implementation of the project during the next phase.

Goal of the evaluation:

> ***to analyze the strategies and activities implemented to date in order to draw lessons to apply, and in order to improve the child survival project***

II. OVERVIEW OF PARTICIPATORY METHODOLOGY

The participatory methodology used in the evaluation includes six phases, each of which has one or more steps. Although many of these steps are similar to those of a 'classic' evaluation, it is important to point out a fundamental methodological difference between the traditional evaluation and participatory evaluation. In the participatory approach, actors and partners of the program are fully involved in each step of the evaluation process.

A. PHASES AND STEPS OF THE PROCESS

The process of participatory evaluation comprises six phases and 17 steps.

Phase I: PRELIMINARY PLANNING MEETINGS

- Step 1 : Define the goal and objectives of the evaluation
- Step 2 : Identify the evaluation team members.
- Step 3 : Plan logistics and administrative arrangements
- Step 4 : Develop visual framework, or the project 'map'

Phase II: EVALUATION PLANNING WORKSHOP

- Step 5 : Set up and guide the evaluation team
- Step 6 : Define the questionnaire
- Step 7 : Identify sources of and techniques for the collection of relevant data.

Phase III: DEVELOPMENT OF DATA COLLECTION TOOLS

- Step 8 : Develop the interview guidelines, observation guides and individual questionnaires

Phase IV: COLLECTION AND ANALYSIS OF DATA

- Step 9 : Orient field teams
- Step 10: Conduct interviews and observations
- Step 11: Analyze data collected
- Step 12: Summarize fieldwork findings

Phase V: WORKSHOP TO FORMULATE LESSONS LEARNED

- Step 13: Review findings and formulate lessons learned
- Step 14: Assess, as a team, the participatory evaluation process

Phase VI: PREPARATION AND DISSEMINATION OF REPORTS

- Step 15: Summarize lessons learned
- Step 16: Prepare the evaluation report
- Step 17: Develop plan of dissemination and discuss evaluation findings

B. CALENDAR OF THE EVALUATION

During an initial brainstorming session with Africare staff, a calendar was established for the implementation of the evaluation. A three-week period was planned for the evaluation process. Compared to a traditional evaluation, a participatory evaluation involving many players requires more time. In the planning phase, it was already apparent that the three-week period would be short. Because of the tight schedule, several members of the team were required to work seven days per week during the three-week evaluation. The phases and steps of the evaluation are summarized in a chart on the following page.

Phase I. Preliminary Planning Meetings

Three days were spent in preliminary planning meetings. The evaluation coordinating group, composed of Wendy Greene, the CS Project Coordinator, Laura Hoemeke, CS Program Manager/Africare, Washington, and Judi Aubel, Evaluation Coordinator, participated in these meetings.

During these meetings, March 13-16, decisions were made concerning the goal and objectives of the evaluation, the identification of the evaluation team members, logistics and administrative arrangements, and the development of a conceptual framework for the evaluation. The elements correspond to Steps 1 through 4 of the evaluation framework proposed by the consultant.

PHASES AND STEPS
IN THE PARTICIPATORY EVALUATION

Phase I:	**PRELIMINARY PLANNING MEETINGS**	Step 1 :	Define the goal and objectives of the evaluation
EVALUATION GROUP	COORDINATING (March 13-16)	Step 2 :	Identify the evaluation team members.
		Step 3 :	Logistics and administrative arrangements
		Step 4 :	Develop the project "map"
Phase II:	**EVALUATION PLANNING WORKSHOP**	**Step 5 :**	Set up and guide the evaluation team
		Step 6 :	Define the questionnaire
		Step 7 :	Identify sources of and techniques for the collection of relevant data.
EVALUATION TEAM (March 17-18)			
Phase III:	**DEVELOPMENT OF DATA COLLECTION TOOLS**	Step 8 :	Develop the interview guidelines, observation guides and individual questionnaires
EVALUATION GROUP	COORDINATING (March 19-20)		
Phase IV:	**COLLECTION AND ANALYSIS OF DATA**	Step 9 :	Orient field teams (March 21)
FIELD TEAMS (March 21-25)		Step 10:	Conduct interviews and observations (March 22-25)
		Step 11:	Analyze data collected (March 22-25)
EVALUATION GROUP	COORDINATING (March 26-28)	Step 12:	Summarize fieldwork findings (March 26-28)
Phase V:	**WORKSHOP TO FORMULATE LESSONS LEARNED**	Step 13:	Review findings and formulate lessons learned
		step 14:	Assess, as a team, the participatory evaluation process
EVALUATION TEAM (March 29-30)			
Phase VI:	**PREPARATION AND DISSEMINATION OF REPORTS**	Step 15:	Summarize lessons learned
		Step 16:	Prepare the evaluation report
		Step 17:	Develop plan of dissemination and discuss evaluation findings
EVALUATION GROUP	COORDINATING (March 3 l-April)		

Step 1 : Define the Goal and Objectives of the Evaluation

Based on the goal set for the evaluation and the priorities of Africare project staff, the objectives of the evaluation were defined. The first three objectives relate to the content of the evaluation. The last objective relates to the methodological approach adopted and the relevance of the participatory evaluation.

Objectives of the evaluation

1. ***to assess progress made in the implementation of activities related to the six components of the project (control of diarrhea1 diseases, child growth monitoringinutrition; maternal health/family planning; immunization; control of malaria; and AIDS)***

2. ***to evaluate the collaboration between the project and community partners, government agencies and services, and non-governmental organizations***

3. ***to study the use and efficiency of the various supporting activities of the project (logistics, training, monitoring, supervision, etc.)***

4. ***to assess the usefulness of the participatory approach of evaluation to participants themselves and to community health projects***

Step 2: Identify the Evaluation Team Members

The coordination team took into consideration several criteria to select members of the evaluation team. The objective was to identify people who had been involved in the project activities in the past, as well as other potential partners. The coordinating group tried to identify individuals who could both contribute to the evaluation and learn from the process.

First of all, the 12 members of the Africare CS project staff of Ganzourgou were included in the evaluation team. At the provincial health department, two nurses (with whom the project collaborate on a regular basis), were identified. In Zorgho, two people were selected from the two institutions with which the project plans to establish relationships in ***the*** future; ***Action Sociale*** and ***Sahel Action.*** At the national level, a representative of the General Direction of the Ministry of Health was identified and also the director of the Office of Non-Governmental Organizations (BSONG, or ***Bureau de Suivi des ONGs***), of the Ministry of Plans.

The evaluation team comprised a total of 21 members, including the consultant who served as the coordinator of the evaluation.

Step 3: Logistics and Administrative Arrangements

The success of every evaluation depends on thorough planning and organization of the administrative and logistic aspects. During preliminary planning meetings, decisions were made concerning the composition of the field teams, the choice of the sites for data collection, the use of the vehicles and drivers for the days on which data **is** collected in the villages, and the choice of a logistician for each field team.

Taking into consideration the tune available for the entire evaluation, it was decided that four days would be spent on data collection; three days for interviews and observations at the village level, and one day to conduct interviews with project staff, the staff of the provincial health department and other Africare/Zorgho partners. During the preliminary planning phase of the evaluation, it was anticipated that some quantitative, as well as qualitative, data should be collected during the evaluation. It also was decided that for data collection at the village level, the project staff would divide into three teams, two of which would collect qualitative data and the other quantitative data.

Step 4: Develop the Project Map

The last step in this preliminary phase consists of the development of a 'map' or visual framework of the project components and indicators to be analyzed during the evaluation. To enable the members of the evaluation team to fully participate in the identification of issues the evaluation should address, all **the** members must have the same understanding of what should be evaluated. The project map, displayed on the wall of the project office conference room, helped the team members understand the various components and indicators of the project, and the links between them that needed to be examined during the evaluation.

During the preliminary meetings, the coordination group spent a day developing the CS project visual framework, which included the various technical components of the project, educational activities, community actors and institutions involved in the activities of the project, and the relationships between the various actors, activities and expected results.

One of the major aspects in the conception of the project strategies defined in the project paper, and a key element of the map, is the following hypothesis:

> ***If the project activities succeed in improving the mothers' understanding and knowledge regarding the various CS themes, the mothers' practices regarding these themes will improve.***

Based on the project map, this hypothesis was examined in-depth throughout the evaluation.

PHASE II: Workshop--Planning the Evaluation

In this participatory approach, members of the evaluation team participated in the definition of the various elements of the evaluation methodology used. At a two-day workshop held at the project site in Zorgho (March 17-18), the 21 members of the evaluation team developed the questions to be addresssed by the evaluation and defined sources of information to be collected as well as the techniques of data collection to use.

The consultant/coordinator of the evaluation prepared the workshop program and played the role of facilitator in concert with the child survival program manager, Africare/Washington.

Step 5: Identify and Guide the Evaluation Team

One of the first objectives of the workshop on planning was to set up the evaluation team and provide guidance to the members of the team on the roles they would play during the evaluation. The effective participation of a group of people in an evaluation, as in any activity, implies that each member of the team feels capable and willing to participate. To achieve this, members of the team must feel comfortable, understand their roles and be able to think about their contribution to the groups' work.

In order to prepare the members of the team to participate in the evaluation, a series of small group exercises are organized on the first day of the workshop. The exercises for this mid-term evaluation workshop focused on: (1) the definition of the evaluation, (2) the 'learning approach' in the implementation and evaluation of programs, (3) the differences between impact and process evaluations, (4) the advantages and disadvantages of traditional versus participatory approaches to project evaluation, (5) the steps in the evaluation of the CS project, and (6) the roles of each participant in the evaluation.

At the end of the first day, the project map (developed in Step 4) was displayed on the wall of the workshop room and presented to the team by the CS Project Coordinator. The visual framework was presented to the members of the team in order to give them an overall view of the project and the indicators to be evaluated. On the second day, the map was used for the development of key elements of the evaluation in Steps 6 and 7.

Step 6: Define the Evaluation Questions

The next step was to consider questions about the project to which the evaluation should provide information. On the second day of the workshop, participants began to develop the various methodological aspects of the evaluation. The participants were divided into four groups, each responsible for the development of questions relating to one aspect of the project map. Using the visual framework as a guide, the small groups worked for four hours dicussing the questions to which the evaluation should provide answers. At the end of this exercise each group presented its proposals at a plenary session for review and comments.

The participation of actors and partners of the project in the definition of the questions that make up the evaluation is of great importance. Their involvement helps to ensure that: (1) the evaluation meets the priorities of project managers and staff; (2) the actors and partners of the project take ownership of the evaluation process, and that (3) the evaluation coordinating group has a clear understanding of the priorities of the project staff in terms of the information to collect during the evaluation.

The results of the groups' work was a list of 132 questions divided into the following categories: general questions on community strategy, training, supervision, health information system, logistics, collaboration with the various partners of the project, educational activities including health talks, home visits, baby weighing sessions and community meetings, and the technical components of the project (immunization, AIDS, nutrition, diarrhea1 diseases, malaria, maternal health and family planning/birth spacing).

Step 7: Identify Sources and Techniques for Data Collection

Once the team had defined the questions to be addressed by the evaluation, the next step was to make decisions regarding each question. For each question, it was to be decided:
(1) whether the information to collect was quantitative and/or qualitative; (2) where and with whom to collect the data; and (3) which data collection techniques to use. Prior to this step in work groups, a presentation of the various methodological options was made, with a focus on the differences between qualitative and quantitative information, potential sources of information to explore, and data collection techniques to use.

Considering the goal and objectives of the evaluation, it was decided that qualitative data collection techniques should be emphasized. Therefore, two field groups were formed to collect qualitative information and a third group was responsible for the collection of qualitative information.

The coordinator of the evaluation presented five techniques of data collection considered as the most appropriate for this type of evaluation of a community health project: (1) individual interviews based on questionnaires; (2) in-depth individual interviews; (3) focus group discussions; (4) observations of activities; and (5) review of available documents and data, Each technique was described and situational cases in which they could be applied provided. The team

members agreed that focus group discussions were a technique to be used as much as possible, given the fact that people usually feel more comfortable in group interviews than in individual interviews. Considering the emphasis on 'health talks' as a major educational activity of the project, it was decided that observations of the talks would be conducted in order to have a clear idea of the implementation of this activity in the villages.

Based on the information made available to the participants on these various methodological elements, the work groups identified the following information for each question:

(1) type of information required (quantitative and /or qualitative);
(2) source(s) of the information to be collected; and
(3) techniques to be used in the collection of data.

At the end of the second day, each group displayed on flipchart the results of their work and the other participants moved around to read and comment on the work of the other groups.

In this second phase of the evaluation, the workshop on planning was useful and the team members participated actively. However, it became apparent that the time available for this second phase (two days), was short. Due to the fact that the total duration of the evaluation was only three weeks, it was not possible to devote more than two days to this workshop. This explains the fact that the entire evaluation team was not able to participate in the development of the interview and observation guides. In the future, it is recommended that at least three days (possibly four) be devoted to the planning workshop so that the program is not overloaded and the participants can be fully involved in the development of tools for the collection of data.

PHASE III: DWELOPMENT OF DATA COLLECTION INSTRUMENTS

Based on the results of the group work during the previous planning phase, instruments for data collection were developed.

Step 8 : Develop Interview Guides, Observation Guides, and Individual Questionnaires

Taking into consideration time constraints, the coordinating group (rather than the entire evaluation team) developed tools for the collection of data. Between March 19th and 20th, the various guides were prepared and duplicated for the members of the field teams.

Collection of qualitative data

Interview guide : For each type of qualitative interview; such as group discussions and in-depth individual encounters, an interview guide was developed. In-depth individual encounters were conducted with the project coordinator, the field supervisor, the program assistant and the provincial health director. Group interview discussions were conducted with (1) mothers of children under five; (2) older women; (3) village leaders and other men; (4) neighborhood health counselors; (5) nurses; (6) project health promoters; and (7) members of Africare Youth Club for Health.

SCHEDULED DATA COLLECTION

Type of Groups	Techniques of Data Collection	# of Interviews Scheduled
mothers of children under 2 years old	interview-questionnaire	100 mothers
mothers of children under 5 years old	focus group discussions	6 to 10 mothers per group/ 6 villages (36-60 women)
older women	focus group discussions	6 to 10 mothers per group/6 villages (36-60 older women)
chiefs + notables	focus group discussions	8 to 12 men per group/6 villages (48-72 men)
neighborhood counsellors	focus group discussions	6-10 per group/6 villages
health promoters	focus group discussions observation of health talk	9 health promoters 1 group/2 villages
project coordinator	in-depth individual interview	1 person
field supervisor	in-depth individual interview	1 person
program assistant	in-depth individual interview	1 person
Provincial Health Director	in-depth individual interview	1 person
nurses	focus group discussions	3 nurses
members of Africare Youth Club for Health	focus group discussions	4 adolescents

Observation guide: To facilitate the observations of health education talks, an observation guide was developed. The guide focuses on the content of the discussion with a particular emphasis on the various aspects of the education and communication techniques used during the session, and the role the health promoter and the participants play.

Collection of Quantitative Data

Interview-questionnaire: In order to assess the knowledge and attitudes of mothers of children under two years of age regarding the six technical components of the project, a questionnaire was developed. It includes 17 questions with a list of anticipated answers.

PHASE IV: COLLECTION AND ANALYSIS OF DATA

As soon as data collection instruments were ready, data collection could begin. One day was devoted to briefing the three field teams. The following four days were spent on data collection and analysis. Throughout this phase, the field team for quantitative data collection conducted household surveys, while the two other field teams were collecting qualitative data.

Step 9: Orient **the Field Teams**

The objective of the orientation was to prepare team members for the collection and analysis of the data they had to gather at the community and institutional levels.

Quantitative team: The orientation of this team included explanations and discussions of each question in the questionnaire in order to understand its objective and possible answers. It also included the translation of the questions into Moore (the local language in Ganzourgou), games, role plays/simulation practice with the questionnaire, and a review of the procedure to follow for the identification of villages and individuals to interview. (Most of these team members had participated in the baseline Knowledge-Attitudes-Practices Survey in 1993 .)

Qualitative teams: The collection of qualitative data can be complex, especially in this case where team members had no specific experience with this type of study. In order to orient the qualitative team members, a series of individual exercises and practice in small groups were conducted. The exercises focused on how the collection of data was to be organized at each village level, the review of the evaluation questions, the guides for each group to observe, the various types of questions to use in the interviews (qualitative/in-depth), verbal and nonverbal behavior which encourage or discourage interviewees into or from giving their opinions, taking notes during interviews, techniques of active listening and logistical organization of village visits.

Step 10: Conduct Interviews and Observations

From March 22-24, interviews and observations were conducted in the villages with the various community actors. On the last day of data collection, interviews were conducted with the project staff and with the various partners within the Ministry of Health and other institutions.

Quantitative team: Four health promoters/supervisors spent two days conducting the interviews in the project villages. Each agent interviewed approximately 25 women.

Quantitative team : The two qualitative teams worked independently; each in three different project villages. Every day, the teams left Zorgho at about 7:00 a.m. to arrive between 7:30 or 8:00 in the villages. Each team included four interviewers who speak Mooré; the language in which all the interviews were conducted. When the team arrived in each village, the team members were divided into two sub-groups. Each sub-group conducted four types of interviews in each village with mothers of children under five, village chiefs and local authorities, old women and neighborhood counselors. **Every day, the teams finished the interviews at 12:00** or 12:30 in order to return to Zorgho and begin data analysis.

Step 11: Analyze the Data Collected

In the case of the quantitative team, the analysis of data took place after all of the interviews had been conducted. The quantitative team, however, analyzed information as it was collected, meeting each afternoon to discuss the mornings' work in the villages.

Quantitative data: On March 25, the members of the quantitative team met to review the results of the interviews and conduct manual tabulation. As planned, each member interviewed approximately 25 women, (totaling 100 interviews).

Qualitative team: Qualitative data needs to be analyzed as soon as possible after it is collected. This effects the timing of data collection in relation to the analysis. During the three days spent collecting data, the team met each afternoon to analyze the data collected.

The analysis of the qualitative data consisted of reading and discussing the answers to interviews in order to prepare and summarize the results obtained for each question. The analysis of qualitative data is not easy and is time consuming. These sessions, facilitated by the two teams coordinators, were very interactive and ended at 7:00 or 7:30 each evening.

On the fourth day of data collection, interviews were conducted in Zorgho with project staff, provincial health department representatives and other collaborators. On these last days, the quantitative team presented a summary of the results of their survey to the evaluation team.

Step 12: Summarize the Fieldwork Findings

Following data collection in Zorgho, the results of the information collected by the field teams were summarized. For each of the 132 questions of the evaluation, conclusions were formulated based on the quantitative and qualitative results. This activity was carried out by the coordinating group between March 26 and 29. When the results were typed and duplicated, they were ready to be presented to the entire team.

PHASE V: WORKSHOP TO FORMULATE LESSONS LEARNED

In the traditional approach to evaluation, based on the findings of the evaluation, recommendations are prepared by the external evaluators. In a participatory approach, the members of the evaluation team are in charge of preparing the recommendations or 'lessons learned' from the evaluation. The participation of the team in this phase is very important in order to ensure that the lessons that are drawn, reflect the findings and are thoroughly understood by all team members. Experience shows that when people participate in the formulation of their own lessons learned, the lessons have a greater chance of being applied in the future.

In order to examine the evaluation findings and prepare the recommendations, a final two-day workshop took place in Zorgho. All 21 members of the evaluation team who had participated in the planning workshop in Phase II attended this work session. During this fifth phase, participants were also requested to prepare their conclusions on the participatory methodology followed throughout the evaluation.

Step 13: Examine Findings and Develop Recommendations

The members of the team were divided into four groups and each group reviewed one fourth of the results, (30 to 40 questions and results). The task for each group was to read and discuss each of the findings submitted, and formulate one or more recommendations for these. The groups preparing the recommendations were instructed to develop clear, concise and feasible recommendations.

The review of the findings and the formulation of recommendations require intense reflection and several hours of time. The groups worked an entire day, (March 29), to prepare their recommendations. On the second day, each group presented its recommendations to the plenary. Each recommendation was examined by the other participants and modified according to discussion and the input of various participants when appropriate.

The director of the provincial health department attended a session on the presentation of all the recommendations on the second day. His presence was highly appreciated and he expressed his satisfaction for the work accomplished during the evaluation.

Step 14: Evaluation of the Participatory Approach

The last step of this phase of the evaluation and the last activity in which all **the team members** took part aimed at encouraging feedback from the participants on the participatory approach to the evaluation. For this purpose, two exercises were conducted. Divided into four groups, participants prepared tables (on flipchart paper) indicating the advantages and disadvantages of the participatory approach. In addition, individual interviews were conducted with each participant. In the interviews, questions were asked about the advantages and disadvantages of this approach, the contribution from each person to the process, what the participants learned during the evaluation, and how the recommendations made could be applied **to** the project activities.

The results of the two exercises are summarized below. On the whole, feedback from the members of the evaluation team in the group exercise and in individual interviews showed that the participants had a positive experience **with** the participatory approach. The ideas expressed during the two exercises focused on several themes, as illustrated by several quotes of the team members.

Advantages of the participation of different actors and partners of the project in the evaluation: The participants concurred that the involvement of various actors and partners of the project in the evaluation was beneficial in that each one was provided with the opportunity to share his or her experiences and views about the various components and activities of the project, and to make suggestions for the future. The participants also said that, compared to their previous experiences with evaiuations, their involvement from the beginning to the end of this process allowed them to understand evaluation, and everyone felt that they had made an important contribution to the process.

Compared to the Last evaluation, this time we were at ease.. . We developed the questions of the evaluation and the recommendations. The recommendations will help me improve my work." (Joanna Ilboudou, Health Promoter, Africare)

The participatory approach was very useful. It enabled me to understand how other people view things. (Palenfo Sié, Action Sociale)

Knowledge acquired by the members of the evaluation team: The members of the team said that their participation in the evaluation enabled them to acquire knowledge in the methodology of participatory evaluation, factors contributing to the success of community health programs, communication techniques with the population and qualitative research.

The evaluation was a training process for all of us. It enabled us to identify the strengths and weaknesses in what is being done. When one himself discovers the problems, he can more easily find the solutions. (Gustave Zombré, Health Promoter, Africare)

I learned a great deal about qualitative research. Now, I hope to be able to collect more data on communities and the ideas of different members. (Haoua Kouama, Health Promoter, Africare)

My participation provided me with the opportunity to understand many things. The more you are involved, the more you learn. (Justine Ouédraogo, Health Promoter, Africare)

Reliability of the evaluation findings: Several participants mentioned the reliability of the results obtained. They strongly believe that the reliability of the results depends on the participation of the various actors and partners of the project in all the phases of the process. They compared this experience with those of other evaluations in which they questioned the reliability of the data collected by external evaluators who are not familiar with the environment and the project.

There is no doubt about the results because we listened to the villagers ourselves. We ***made the recommendations ourselves on the spot; thus, we will be able to retain them more easily.*** (Charles Ouédraogo, Health Agent, Provincial Health Department of Ganzourgou)

Appropriateness and relevance of the recommendations made: The participants said that as the recommendations or 'lessons' of the evaluation were developed by them and in the context of their project, they are both relevant and feasible. The participants are therefore committed to implementing them.

The results of this evaluation will serve as a guideline for us in the implementation of activities during the rest of the project. (Amélie Kaboré, Health Promoter, Africare)

You could even call this a reportless evaluation, because we don't really need a report. We already have all of the recommendations in our heads. (Abdoulaye Tiemtoré, Sahel Action)

We are in a hurry to put into practice what we have learned. (Abzeta Kaboré, Health Promoter, Africare)

Reinforcement of solidarity within the team: Many of the members of the evaluation team, as well as the actors of the project and partners of other institutions, pointed out that the full involvement and collaboration of all the participants in the work groups during the three weeks of the evaluation, reinforced the team spirit that should prevail in the implementation of the project activities.

The involvement of everyone reinforced the team spirit. There now exists a stronger feeling of project ownership by the members of the team. (Wendy Greene, Ganzourgou Child Survival Project Coordinator, Africare)

Appreciation of the perspective of the community: Many participants said that the approach to qualitative data collection (with the use of community actors), helped them increase their comprehension and appreciation of the community perspective.

I realized that in our contact with the population, we should not only try to transfer our knowledge, but also learn from them. (Philippe Traore, Health Agent, Ganzourgou Provincial Health Department)

The relevance of the participatory evaluation methodology to community health projects:

I think that this type of evaluation is valuable not only for health projects, but for all community development projects. (Pascal Tiendrébéogo, Health Promoter, Africare)

PHASE VI: PREPARATION AND DISSEMINATION OF THE REPORT

In this last phase of the evaluation, the coordination group needed to perform several tasks to complete the evaluation.

Step 15: Summary of the Lessons Learned

Based on the number of recommendations, it was important to summarize them in order to make them more accessible, The 132 recommendations were summarized in the groups of questions established in the first phase of the evaluation, namely (1) the community approach, (2) training, (3) supervision, (4) health information system, (5) cooperation with the different partners of the project, (6) educational activities and (7) project technical components.

Community approach

In the past, CS activities supported by the project have been carried out primarily by the project personnel, especially the health promoters. In order to achieve sustainability of improved maternal and child health at the community level, the health promoters must encourage community actors, neighborhood counselors, traditional chiefs and authorities to play an active role in the organization of CS activities. It is also essential that the role of the different community actors must be clearly defined and understood by everybody, especially by the traditional village chiefs and other authorities.

Because more than one third of the community volunteers (neighborhood counselors) already have basically dropped out of project activities, it is essential that their situation be discussed with the community leaders in order to find a system whereby the community can provide incentives and increase motivation.

The objectives defined in the project paper are to change mothers' attitudes towards different aspects of CS. The project is based on the assumption that by changing the knowledge and attitudes of the mothers, a project can positively change their practices. Based on this assumption most of the activities of the project target mothers of children under 5 years of age. The evaluation concluded that changes in knowledge and attitudes of mothers do not automatically result in changes in practice. This is primarily because of the strong influence that other persons in the family and the community have over young mothers. The project strategy

must be modified to focus on actions geared towards the change of community norms rather than in the behavior of individual mothers. This reorientation implies that education activities should target not only young mothers, but also target other people in the community capable of influencing the attitudes of the mothers (their husbands, old women, traditional chiefs/authorities, healers, etc.)

Training

During the implementation of the project, training workshops were organized and some staff members participated in the training activities organized by other structures and institutions. However, a comprehensive training strategy for community and institutional actors involved in the project activities, has not yet been developed. The project must develop a training/retraining plan for the various groups of actors, taking into account the roles and tasks of each of them. In the past the training provided to the project staff and community leaders, focused on the technical aspects of CS. Based on the analysis of the tasks, further emphasis needs to be put on practical elements of community approach and education/communication techniques **to use** in the implementation of the activities. In any training, methods of actual learning/education of adults should be used. For each training activity a detailed plan of the sessions needs to be prepared in advance, and a report of the training submitted.

In order to encourage self-training, more simple technical documents need to be made available to the health promoters and counselors on a regular basis.

Supervision/Evaluation of the Project Staff

The feedback from supervision of the project activities at the village level has tended to be quantitative. Supervision tools need to be reviewed to include all the CS activities implemented in the village, and also to include qualitative analysis. This should encourage recommendations from the field, and subsequently contribute to improving the way project activities are carried out.

A system of performance evaluations will increase project staff motivation.

Health Information System

The HIS includes quantitative data exclusively. It needs to be revised to include elements of qualitative information, and a mechanism for the collection of data on community appreciation of the activities implemented, to enable the formulation of "lessons learned" on a regular basis, and to assure feedback to community leaders.

Logistics

In order to address the transportation problem project health promoters are facing, a series of measures need to be taken: supply of fuel should take into account the geographic area covered by each agent, the quality of the 'moped' maintenance service needs to be monitored, and the possibility of establishing a system of rental-sale of the project mopeds needs to be explored.

Cooperation with the various Partners of the Project
The good cooperation between the project staff and the Provincial Health Department (PHD) can be reinforced via ongoing, regular meetings between the project managers and the director of the PHD, the official submission of monthly reports to the director, and the organization of quarterly meetings between health agents and health promoters.

Education Activities
Education activities carried out through the project have thus far, been organized by the health promoters. In the future, the health promoters should try to upgrade the skills and increase the motivation of community leaders to carry out their own activities for the promotion of CS.

Traditional means of communication such as songs, dance, tales, sketches/theater, and community meetings need to be examined and used in the promotion of CS. These means are simple, sustainable and adapted to the culture of the Ganzourgou community.

Conciousness-raising activities must target mothers of children, old women, husbands, traditional leaders and authorities. To analyze ongoing sensitization activities, mini-surveys can be conducted on a regular basis and followed through with recommendations.

Discussion
The approach used in this major conciousness-raising activity, needs to be revised to increase its impact: a pedagogical approach based on practical learning should be adopted. Participants in the discussions need to be a homogenous group for increased participation, (of women in particular). The size of the groups who attend the discussions has to be reduced, (20-30 persons maximum), and in order to enable the effective participation of the community members during the discussions, the role of the health promoter must not be confined to "transferring messages;" he must also encourage reflection and dialogue on the themes covered.

Home Visits
The main goal of home visits is to monitor children at risk of malnutrition and suffering from diarrhea. Currently the number of visits made by the health promoters is very limited (O-4 per month/per village and the number made by the neighborhood counselors is less). The number **of home** visits has to be increased as well as the quality of interpersonal communication and advice given during these visits. It is necessary to upgrade the skills of the counselors in the organization of the visits, and assist them to make them on a regular basis based on the needs of specific households.

Growth Monitoring
Much emphasis has been put on regular child weighing in the project. In order to improve the quality of this activity and its' impact on the nutritional status of children several measures need to be adopted: The results of the weighing recorded on the growth curves, need to be replaced by another system which can be better understood by mothers, reinforce the skills of the health promoters and neighborhood counselors in

interpersonal communication, including techniques of negotiation with mothers, and motivation of community leaders to carry out their own activities for the promotion of CS. Traditional means of communication such as songs, dance, tales, sketches/theater and community meetings, need to be examined and used in the promotion of CS. These means are simple, sustainable and conform to the culture of the communities.

Community Meetings

The project should clearly define the role of the chiefs/authorities in the organization and conduction of meetings in order to reinforce the use of community meetings as a means of communication in the CS. This is also important in order to assure that the latter take more initiatives themselves, diversify the themes covered and the sensitization and communication approaches used at these meetings. This includes discussions with homogeneous groups (men, women, old women etc) followed by a plenary session with all community groups.

Technical Components of CS

Small scale qualitative studies need to be conducted at the community level by the health promoters for every technical components of CS. In so doing, the project staff will have detailed information on the knowledge and attitudes of the population relating to the various CS themes. This information will enable them to develop conciousness-raising activities that take into consideration the reality and experiences of the communities.

HIV/AIDS

AIDS activities with the Youth Club have to be intensified by multiplying the types of educational strategies used immediately after the performances'. The Club should also diversify its' activities to include other CS health themes. By encouraging income-generating projects by club members, the Club could assure a degree of sustainability.

AIDS related activities at the village level need to be reinforced by community mobilization and consciousness-raising in order to increase their effect. Particularly important is the need to increase the sale of condoms by village vendors.

Nutrition

The promotion of enriched porridge prepared with local products must continue. The importance of colostrum needs to be stressed. Nurses must be trained and technical documents on breast-feeding developed. The project also needs to develop activities addressing the specific needs of pregnant women.

Diarrhea1 Diseases

For this intervention, emphasis is put on the use of ORS and referral to health centers in cases of acute diarrhea. The health promoters and neighborhood counselors in the future, must put emphasis on caring for diarrhea at home using locally available fluids, breast-feeding and appropriate feeding. Influential persons such as old women and

husbands, have to be involved in these activities in order to assure their sustainability in the community.

Malaria
Because of the remoteness of the CSPS, emphasis should be put on the prevention of malaria and home care for sick children. Influential persons within the community such as the chiefs, authorities and others, must be actively involved in malaria prevention measures taken.

Maternal Health and Birth Spacing/Family Planning

To assure sustainability, the project must work further with old women and with men in activities related to maternal health. Men, older women, and other influential persons, must be involved in family planning activities. Men who influence the availability of family resources, and the eating practices in the household, need to be targeted for education and conciousness-raising about the importance of maternal care, nutrition, and family planning to the family as a whole.

Step 16: Preparation of the Report

In a traditional evaluation the evaluators sit behind closed doors for some days to prepare the content as well as the format of the report. In the case of a participatory evaluation, the preparation of a report is quite different. The report will be a compilation of the discussions and decisions taken by the whole evaluation team.

In this specific case, the report not only includes the conclusions of the work accomplished by the team, but also as you have noticed, a description of the methodology followed. The decision to include these elements in the report is based on the idea that this can be of used to those who wish to use the methodological approach to their respective evaluation activities.

Step 17: Define an Evaluation Report Distribution Plan

An important aspect of any evaluation is for the results to be available to those who can use them. This will of course include the persons who are directly concerned, but should also include other managers or agents working in similar projects/programs in country.

There is a need to: (1) identify the people who might be interested in receiving information about the evaluation. (2) identify the best way to communicate this information to them.

Following Phase V, the CS Project Coordinator and the CS Program Manager Africare/Washington, prepared a plan for report dissemination and review, in the form of a table containing these two types of information.

IV. PROGRAMMATIC AND METHODOLOGICAL CONCLUSIONS

A. PROGRAMMATIC CONCLUSIONS RELATING TO CS PROGRAMS AND PROJECTS

Like many CS projects, the Ganzourgou CS Project paper assummes that increased knowledge of mothers through education, and improved attitudes due to consciousness-raising activities, will lead to change in the habits and behavior. But the habits and behaviors of mothers in the villages are more readily influenced by the opinion of people around them (husbands, old women, and relatives living in the same community), than by their own knowledge or attitude.

This conclusion suggests that IEC objectives in CS proposal documents must take into consideration social norms, and focus on changes in knowledge, attitudes and practices of influential persons, as well as of mothers.

Training

In order to identify training needs in CS programs or projects, it is important that the roles and responsibilities of each type of community and institutional actor, be clearly defined at the beginning of the project. Once this is clear, the training and retraining curricula should be developed, and an overall strategy for all the training activities planned. This needless to say, requires a person who has experience in training and curriculum development.

Participatory teaching methods favor adult learning, whether they are community members or project agents. All training activities must be oased on these methods.

Continued supervision of community and institutional actors and activities can help achieve efficiency in activities. Monitoring should be based on qualitative and quantitative criteria and enable project staff to continuously develop recommendations which can immediately be applied to reinforce the implementation of activities. The HIS must be a monitoring tool; helping project staff make decisions for the improvement or reorientation of activities. To meet this expectation, the HIS should include qualitative and quantitative data.

Collaboration with different project partners

Close collaboration with the Ministry of Health is essential to assure that activities are in line with the policy and priorities of the ministry. Moreover, the close collaboration with the MOH can contribute to the reinforcement of community approach techniques for the ministry personnel.

Health education activities

The impact of health education activities on the one hand, depends on the degree of community group participation in the activities. The project must put emphasis on the approaches and the activities requiring participation and analysis of CS themes, rather than on the one-way transfer of health messages.

Messages and advice
The capacity to sustain CS education activities at the community level, depends on the acquisition of knowledge and skills by community actors, the existence of a monitoring system, and the existence of incentives and remunerations within the community itself. Traditional methods of communication are likely to be sustained due to the fact that they are simple and less expensive.

The technical components of CS
It is important that cultural attitudes and habits of the population regarding the various CS themes be reflected in the way CS activities are carried **out. People** learn better when they can relate to what they see and hear. (i.e. the types of educational materials, and the form and language used for the transfer of information). With this in mind, project staff can conduct mini-surveys of the various groups within the community for the collection of qualitative data.

The evaluation revealed that, in several cases, the technical assistance provided by the project staff is not always adapted, nor is it always appropriate. To assure that they are in line with the priorities of the ministry, the monitoring of the project activities must enable a periodic control of the technical contents communicated in education or counseling sessions.

B. METHODOLOGICAL CONCLUSIONS ON THE PARTICIPATORY APPROACH

The evaluation methodology adopted favored the participation of members of the project staff, colleagues in the Ganzourgou Provincial Health Department and partners at the national level. Concerning the relevance of participatory methodology; the feedback from all of the evaluation team members was favorable. The participation of the actors and partners of the project in all the steps of the evaluation, contributed to creating a feeling of ownership. The process and the outputs of the evaluation assure that the evaluation addresses the priority issues of the actors and partners of the project, and reinforces the team spirit that exists between the actors and partners of the project. It also increased team members' knowledge of evaluation methods and more particularly re-emphasized the need to collect qualitative data.

The time allocated to the evaluation was three weeks. Though the methodology was highly appreciated by all Africare staff and management, the three-week period was not long enough. Because this approach serves both as a training exercise for those involved and as an evaluation, it is strongly recommended that in the future, an evaluation using the participatory approach be alloted a four-week period of time.

1995 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

Check one: ORIGINAL BUDGET_____ REVISED BUDGET_____

PVO/COUNTRY: AFRICARE/BURKINA FASO
COOPERATIVE AGREEMENT NO.: FAO-0500-A-00-3024-00
DATE BUDGET PREPARED: 8/15/95
DATE SUBMITTED TO USAID: 8/30/95

		Total Agreement Budget 10/93 – 09/96		Actual Expenditures 10/93 – 06/95		Projected Expenditures 07/95 – 09/96		TOTAL
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	YEARS 1-3
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters-salaries/wages	$107,889	$960	$38,383	$0	$69,506	$960	$108,849
	2. Field, Technical Personnel-salaries/wages	$0	$0	$0	$0	$0	$0	$0
	3. Field, Other Personnel-salaries/wages	$0	$0	$0	$0	$0	$0	$0
	4. Fringes- Headquarters + Field	$24,064	$0	$20,124	$0	$3,940	$0	$24,064
	SUBTOTAL- PERSONNEL	$131,953	$960	$58,507	$0	$73,446	$960	$132,913
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)	$14.400	so	$2.347	$0	$12,053	$0	$14,400
	2. Headquarters-International	$22,600	so	$21,512	so	$1,088	so,	$22,600
	3. Field- In country	so	so	so	so	so	so	$0
	4. Field- International	$0	$0	$0	$0	$0	$0	$0
	SUBTOTAL- TRAVEL / PER DIEM	$37,000	$0	$23,859	$0	$13,141	$0	$38,464
C. CONSULTANCIES	1. Evaluation Consultants- Fees	$18,950	$0	$9,744	$0	$9,206	$0	$18,950
	2. Other Consultants- Fees	$0	$4,875	$0	$0	$0	$4,875	$4,875
	3. Consultant travel / per diem	$10,400	$0	$8,612	$0	$1,788	$0	$10,400
	SUBTOTAL- CONSULTANCIES	$29,350	$4,875	$18,356	$0	$10.9911	$4,875	$34,225
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies a. Headquarters	$6,310	$1,920	$2,948	so	$3.362	$1,920	$6,230-
	b. Field – Pharmaceuticals (ORS, Vit. A, drugs, etc.)	so	$0	so	so	so	so	$0
	c. Field- Other	so	$0	so	so	so	so	so
	2. Equipment a. Headquarters	$450	$3,000	$4,493	so	($4.043)	$3,000	$3,450
	b. Field	so	so	so	$0	so	so	so
	3. Training a. Headquarters	$2,850	$0	$105	$0	$2,745	$0	$2,850
	b. Field	$0	so	$0	$0	$0	$0	so
	SUBTOTAL- PROCUREMENT	$9,610	$4,920	$7,546	$0	$2,064	$4,920	$14630
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications a. Headquarters	$10,800	so	$4,267	$0	$6.533	$0	$10.800
	b. Field	so	so	so	so	so	so	so.
	2. Facilities a. Headquarters	$0	$0	$0	$0.	$0	$0	$0
	b. Field	so	$0	$0	so	so	so	so
	3. Other a. Headquarters	$500	$0	$126	$0	$374	$0	$500
	b. Field	so	$0	$0	$0	$0	$0	so
	SUBTOTAL- OTHER DIRECT	$11,300	$0	$4,393	$0	$6,907	$0	$11,300
TOTAL – DIRECT COSTS		$219,213	$10,755	$112,661	$0	$106,552	$10,755	$229,968
II. INDIRECT COSTS								
A. INDIRECT COSTS	1. Headquarters	$174,423	$53,437	$123,838	$322	$50,585	$53,115	$227,860
	2. Field (if applicable)	$0	$0	$0	$0	$0	$0	$0
TOTAL – INDIRECT COSTS		$174,423	$53,437	$123,838	$322	$50,585	$53,115	$227,860
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		$393,636	$64,192	$236,499	$322	$157,137	$63,870	$457,828

1995 PIPELINE ANALYSIS: PART B - COUNTRY BUDGET

Check one: ORIGINAL BUDGET_____ REVISED BUDGET_____

PVO/COUNTRY: AFRICARE
COOPERATIVE AGREEMENT NO.: FAO-0500-A-00-3024-00
DATE BUDGET PREPARED: 8/15/95
DATE SUBMITTED TO USAID: 8/30/95

		Total Agreement Budget 10/93 – 09/96		Actual Expenditures 10/93 – 06/95		Projected Expenditures 07/95 – 09/96		TOTAL
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	YEARS 1-3
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters-salaries/wages	$0	$0	$0	$0	$0	$0	$0
	2. Field, Technical Personnel-salaries/wages	$152,879	$0	$76,931	$0	$75,948	$0	$152,879
	3. Field, Other Personnel-salaries/wages	$83,872	$0	$60,889	$0	$22,983	$0	$83,072
	4. Fringes- Headquarters + Field	$76,201	$0	$24,729	$0	$51,472	$0	$76,201
	SUBTOTAL- PERSONNEL	$312,952	$0	$162,549	$0	$150,403	$0	$312,952
B. TRAVEL/PER DIEM	1. Headquarters- Domestic (USA)	$0	$0	$0	$0	$0	$0	$0
	2. Headquarters- International	$0	$0	$0	$0	$0	$0	$0
	3. Field- In country	$54,675	$30,200	$47,509	$142	$7,166	$30,058	$84,875
	4. Field- International	$18,500	$0	$27,937	$0	($9,437)	$0	$18,500
	SUBTOTAL- TRAVEL / PER DIEM	$73,175	$30,200	$75,446	$142	($2,271)	$30,058	$103,375
C. CONSULTANCIES	1. Evaluation Consultants- Fees	$0	$0	$0	$0	$0	$0	$0
	2. Other Consultants- Fees	$0	$0	$0	$0	$0	$0	$0
	3. Consultant travel / per diem	$0	$0	$0	$0	$0	$0	$0
	SUBTOTAL- CONSULTANCIES	$0	$0	$0	$0	$0	$0	$0
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	$0	$0	$0	$0	$0	$0	$0
	c. Field- Other	$27,700	$111,100	$11,720	$20	$15,980	$111,080	$138,800
	2. Equipment a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field	$26,000	$106,050	$5,271	$0	$20,729	$106,050	$132,050
	3. Training a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field	$38,900	$0	$11,994	$960	$26,906	($960	$38,900
	SUBTOTAL- PROCUREMENT	$92,600	$217,150	$28,985	$980	$63,615	$216,170	$309,750
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field	$21,200	$0	$16,413	$0	$4,787	$0	$21,200
	2. Facilities a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field	$22,750	$0	$5,421	$0	$17,329	$0	$22,750
	3. Other a. Headquarters	$0	$0	$0	$0	$0	$0	$0
	b. Field	$17,825	$1,300	$9,623	$72	$8,202	$1,228	$19,125
	SUBTOT M - OTHER DRECT	$61,775	$1,300	$31,457	$72	$30,318	$1,228	$63,075
TOTAL - DIRECT COSTS		$540,502	$248,650	$298,437	$1,194	$242,065	$247,456	$789,152
II. INDIRECT COSTS								
A. INDIRECT COSTS	1. Headquarters	$0	$0	$0	$0	$0	$0	$0
	2. Field (if applicable)	$0	$0	$0	$0	$0	$0	$0
TOTAL - INDIRECT COSTS		$0	$0	$0	$0	$0	$0	$0
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		$540,502	$248,650	$298,437	$1,194	$242,065	$247,456	$789,152

TOTAL PROJECT

1995 PIPELINE ANALYSIS: PA , C - HEADQUARTERS/FIELD BUDGET

Chock ON.: ORIGINAL BUDGET_____ REVISED BUDGET_____

PVO/COUNTRY: AFRICARE/BURKINA
COOPERATIVE **AGREEMENT** NO.: FAO-0500-A-00-3024-00
DATE **BUDGET** PREPARED: 8/15/95
DATE **SUBMITTED** TO **USAID:** 8/30/95

		Total Agreement Budget 10/93 – 09/96		Actual Expenditures 10/93 – 06/95		Projected Expenditures 07/95 – 09/96		TOTAL
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	YEARS 1 –3
A PERSONNEL (salaries, wages, fringes)	1. Headquarters – salaries/wages	$107,889	$960	$38,383	$0	$69,506	$960	$108,8
	2 Field, Technical Personnel – salaries/wages	S $152,879	$0	$76,931	O	$75,948	$0	$152,8
	3. Field, Other Personnel – salaries/wages	$83,872	$0	$60,889	$0	$22,983	$0	$83,8
	4. Fringes- Headquarters + Field	$100,265	$0	$44,853	$0	$55,412	$0	$100,2
	SUBTOTAL- PERSONNEL	$444,905	$960	$221,056	$0	$223,849	$960	$445,8
B. TRAVEL/PER DIEM	1 . Headquarters – Domestic (USA)	$14,400	$0	$2,347	$0	$12,053	$0	$14,4
	2 Headquarters – International	$22,600	$0	$21,512	$0	$1,088	$0	$22,6
	3. Field- In country	$54,675	$30,200	$47,509	$142	$7,166	$30,058	$84,8
	4. Field – International	$18,500	$0	$27,937	$0	($9,437)	$0	$18,5
	SUBTOTAL – TRAVEL / PER DIEM	$110,175	$30,200	$99,305	$142	$10,870	$30,058	$140,3
C. CONSULTANCIES	1. Evaluation Consultants – Fm	$18,950	$0	$9,744	$0	$9,206	$0	$18,9
	2 Other Consultants – F m	$0	$4,875	$0	$0	$0	$4.675	$4,8
	J. Consultant travel I per diem	$10,400	$0	$8,612	$0	$1,788	$0	$10,4
	SUBTOTAL- CONSULTANCIES	$29,350	$4,875	$18,356	$0	$10,994	$4.675	$34,2
D. PROCUREMENT (provide justification/ ● ☒O♦&O ☓■ narrative)	1. Supplies . . Headquarters	$6,310	$1,920	$2,948	$0	$3,362	$1.920	$8,2
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	$0	$0	$0	$0	$0	$0	
	c. Field – Other	$27,700	$111,100	$11,720	$20	$15,980	$111,080	$138,8
	2 Equipment a. Headquarters	$450	$3,000	$4,493	$0	($4,043)	$3,000	$3,4
	b. Field	$26,000	$106,050	$5,271	$0	$20,729	$106.050	$132,0
	3. Training a. Headquarters	$2,850	$0	$105	$0	$2,745	$0	$2,8
	b. Field	$38,900	$0	$11,994	$960	$26,906	($960)	$38,9
	SUBTOTAL – PROCUREMENT	$102,210	$222,070	$36,531	$980	$65,679	$221,090	$324,2
E. OTHER DIRECT COSTS (provide justification/ ● qhmtion in narrative)	1. Communications a. Headquarters	$10,800	$0	$4,267	$0	$6,533	$0	$10,8
	b. Field	$21,200	$0	$16,413	$0	$4,787	$0	$21,2
	2. Facilities a. Headquarters	$0	$0	$0	$0	$0	$0	
	b. Field	$22,750	$0	$5,421	$0	$17,329	$0	$22,7
	3. Other a. Headquarters	$500	$0	$126	$0	$374	$0	$5
	b. Field	$17,825	$1,300	$9,623	$72	$8,202	$1,228	$19,1
	SUBTOTAL – OTHER DIRECT	$73,075	$1,300	$35,850	$72	$37,225	$1,228	$74,3
TOTAL – DIRECT COSTS		$759,715	$259,405	$411,098	$1,194	$348,617	$258,211	$1,019,1
II. INDIRECT COSTS								
A. INDIRECT COSTS	1. Headquarters	$174,423	$53,437	$123,838	$322	$50,585	$53,115	$227,8
	2. Field (if applicable)	$0	$0	$0	$0	$0	$0	
TOTAL – INDIRECT COSTS		$174,423	$53,437	$123,838	$322	$50,585	$53,115	$227,8
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		$934,138	$312,842	$534,936	$1,516	$399,202	$311,326	$1,246,9